number and length of health-care visits. For our analysis, the total time spent with a primary health-care professional was calculated. Centers for Epidemiologic Studies – Depression (CES-D, representing symptom-based severity of depression) and Quality of Life Depression Scale (QLDS, depression-specific quality of life) data were gathered from a sample of patients self-reporting depressive symptoms, but not necessarily having a diagnosis of depression.
RESULTS: Using the cross-sectional baseline measurement point, a total of 2359 patients were evaluated across the sites. Dividing the population by CES-D scores (<20, $\geqslant 20$), all sites except St. Petersburg had a pattern where those with lower CES-D scores (less depressive symptomatology) spent less time with their doctors than those with more moderate to severe depression (ranging from 1 minute in Barcelona to over 10 minutes in Seattle). Comparing groups split by mean quality of life scores, a similar pattern was noted with those having lower quality of life spending less time with their health care provider (1 minute in Melbourne to 10 minutes in Seattle).
CONCLUSION: With the exception of the site in St. Petersburg, primary care patients who self-report depressive symptoms and lower quality of life tend to spend more actual contact time with their health-care providers.

PMH19

IDENTIFICATION AND ONE-YEAR COSTS OF TREATMENT-RESISTANT DEPRESSION IN A CLAIMS DATA ANALYSIS

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OBJECTIVE: Major depressive disorder (MDD) is a debilitating condition with significant economic consequences. Estimates indicate that up to 30% of individuals with MDD are treatment resistant (TRD). The study objectives were (a) evaluation of studying TRD using claims data; (b) estimation of cost differences between TRD and non-TRD patients.
METHODS: Data source was administrative claims data from a Fortune 100 manufacturer. Claims included medical, pharmaceutical and disability claims for 1996–1998 ($n > 100{,}000$). The sample was restricted to claims for MDD (NMDD = 4,186). Using a treatment algorithm, patients were classified into TRD-likely and TRD-unlikely groups (NTRD = 487). Resource utilization was compared between TRD-likely, TRD-unlikely patients, and a sample of the overall population.
RESULTS: The algorithm classified twelve percent of the MDD sample as TRD. Average annual costs were $10,954 for TRD-likely patients, $5,025 for TRD-unlikely patients, and $3006 for average beneficiaries. The average number of health claims among TRD-likely patients were one and a half times greater than that of TRD-unlikely patients.
CONCLUSION: Resource utilization by TRD-likely patients is substantial, not only for direct treatment of depression but also for treatment of co-morbid medical conditions. Additionally, TRD imposes substantial indirect costs on employers, primarily resulting from high rates of depression-associated disability.

PMH20

COMPARISON OF ADVERSE DRUG EVENTS (ADE) ASSOCIATED WITH SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI) IN TWO MANAGED CARE ORGANIZATIONS (MCO)

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OBJECTIVE: To compare Adverse Drug Events (ADE) associated with Selective Serotonin Reuptake Inhibitors (SSRI) in two Managed Care Organizations (MCO).
METHODS: Medical records for two MCOs in central Texas were reviewed. Scott and White Health Plan (SWHP) is a general health plan and Alamo Mental Health Group (AMHG) is a behavioral/mental health organization. Inclusion criteria for both settings were patients over 18 years old that had a diagnosis of depression and had a new prescription for an SSRI.
RESULTS: A total of 337 patients in SWHP and 361 patients in AMHG met the inclusion criteria. About 40% (N = 135) of SWHP patients and 40% (N = 144) of AMHG patients had at least one adverse drug event (ADE) associated with an SSRI noted in their medical record. The most common ADEs reported were sleep cycle disturbances, e.g. insomnia, daytime sedation 13(%); GI disturbances, e.g. diarrhea, nausea/vomiting 11(%); sexual dysfunction 7(%); and anxiety/nervousness 5(%). Of those with reported ADEs (N = 135 + 144 = 279), at least one therapy change due to ADEs was made for 71% (N = 96) of the SWHP patients and 69% (N = 100) of the AMHG patients: 25% were switched to another antidepressant; 20% had a medication added; 19% had a change in the dose/regimen of their index medication; 12% discontinued their index medication. The most common medication added to treat side effects at SWHP was trazodone, while the most common addition at AMHG was bupropion.
CONCLUSIONS: Although the health-care settings differed in type (general versus behavioral/mental health), results were strikingly similar. About 40% of the patients reported ADEs and of these, about 70% had at least one change made to their therapy, many discontinuing the original medication. Strategies for treating ADEs appeared to vary by setting, which may have cost implications. Future research might examine the impact of ADE strategies and patient education on continuity of treatment.